Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

NATIONAL QUALITY MEASURES CLEARINGHOUSE

General

Title

Heart failure (HF): percentage of HF patients discharged from a hospital inpatient setting to home or home care for whom a follow-up appointment for an office or home health visit for management of HF was scheduled within 7 days post-discharge and documented including location, date, and time.

Source(s)

The Joint Commission. Disease-specific care certification program. Advanced certification heart failure: performance measurement implementation guide. Oakbrook Terrace (IL): The Joint Commission; 2015 Mar. 76 p.

Measure Domain

Primary Measure Domain

Clinical Quality Measures: Process

Secondary Measure Domain

Does not apply to this measure

Brief Abstract

Description

This measure is used to assess the percentage of heart failure (HF) patients discharged from a hospital inpatient setting to home or home care for whom a follow-up appointment for an office or home health visit for management of HF was scheduled within 7 days post-discharge and documented including location, date, and time.

Rationale

Care coordination is important for all patients, but especially for vulnerable populations, such as patients with heart failure and other chronic diseases. Today, the average Medicare patient sees two primary care and five specialists per year. For patients with multiple chronic conditions, the number of healthcare providers involved in the care of the patient is even higher.

The exchange of information from one healthcare provider to another should smooth the transition of care from the inpatient to outpatient setting. According to Bell and colleagues (2009), the separation of hospital and ambulatory care may result in significant care discontinuities after discharge. Therefore, it is paramount that discussions between providers summarize the patient's history and communicate the plan for follow-up care after discharge in order to be effective. When done well, this exchange of information can avoid conflicting plans of care; overuse, underuse, and misuse of medications, tests and therapies; reduce costs and potentially adverse events.

The Joint Commission's 2014 Disease-Specific Care Advanced Certification Heart Failure standards require: The program [to provide] care coordination services across inpatient and outpatient settings. Scheduling of the initial follow-up appointment with the primary care provider is a first-step to ensuring continuity of care. In addition, standards require that care, treatment, and services are provided in a planned and timely manner, which includes the arrangement of a follow-up appointment with a health care provider to occur within seven days after discharge.

Evidence for Rationale

American College of Cardiology Foundation, American Heart Association, Physician Consortium for Performance ImprovementÂ®. Heart failure performance measurement set. Chicago (IL): American Medical Association; 2011 Jan. 85 p. [51 references]

American Heart Association (AHA). Get With The GuidelinesÂ® outpatient fact sheet. Dallas (TX): American Heart Association (AHA); 2010.

Bell CM, Schnipper JL, Auerbach AD, Kaboli PJ, Wetterneck TB, Gonzales DV, Arora VM, Zhang JX, Meltzer DO. Association of communication between hospital-based physicians and primary care providers with patient outcomes. J Gen Intern Med. 2009 Mar;24(3):381-6. PubMed

Hunt SA, Abraham WT, Chin MH, Feldman AM, Francis GS, Ganiats TG, Jessup M, Konstam MA, Mancini DM, Michl K, Oates JA, Rahko PS, Silver MA, Stevenson LW, Yancy CW. 2009 focused update incorporated into the ACC/AHA 2005 guidelines for the diagnosis and management of heart failure in adults: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines [TRUNC]. Circulation. 2009 Apr 14;119(14):e391-479. [810 references] PubMed

Lindenfeld J, Albert NM, Boehmer JP, Collins SP, Ezekowitz JA, Givertz MM, Klapholz M, Moser DK, Rogers JG, Starling RC, Stevenson WG, Tang WH, Teerlink JR, Walsh MN. Executive summary: HFSA 2010 comprehensive heart failure practice guideline. J Card Fail. 2010;16:475-539.

The Joint Commission. Disease-specific care certification program. Advanced certification heart failure: performance measurement implementation guide. Oakbrook Terrace (IL): The Joint Commission; 2015 Mar. 76 p.

The Joint Commission. The Joint Commission's 2014 disease-specific care certification manual: advanced certification in heart failure addendum. Oakbrook Terrace (IL): The Joint Commission; 2014.

Primary Health Components

Heart failure; management; post-discharge follow-up

Denominator Description

All heart failure patients discharged from a hospital inpatient setting to home or home care (see the

related "Denominator Inclusions/Exclusions" field)

Numerator Description

Patients for whom a follow-up appointment for an office or home health visit for management of heart failure was scheduled within 7 days post-discharge and documented including location, date, and time

Evidence Supporting the Measure

Type of Evidence Supporting the Criterion of Quality for the Measure

A clinical practice guideline or other peer-reviewed synthesis of the clinical research evidence

Additional Information Supporting Need for the Measure

Unspecified

Extent of Measure Testing

Unspecified

State of Use of the Measure

State of Use

Current routine use

Current Use

not defined yet

Application of the Measure in its Current Use

Measurement Setting

Ambulatory/Office-based Care

Home Care

Hospital Inpatient

Hospital Outpatient

Transition

Type of Care Coordination

Coordination across provider teams/sites

Coordination between providers and patient/caregiver

Professionals Involved in Delivery of Health Services

not defined yet

Least Aggregated Level of Services Delivery Addressed

Individual Clinicians or Public Health Professionals

Statement of Acceptable Minimum Sample Size

Specified

Target Population Age

Age greater than or equal to 18 years

Target Population Gender

Either male or female

National Strategy for Quality Improvement in Health Care

National Quality Strategy Aim

Better Care

National Quality Strategy Priority

Effective Communication and Care Coordination
Prevention and Treatment of Leading Causes of Mortality

Institute of Medicine (IOM) National Health Care Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Timeliness

Data Collection for the Measure

Case Finding Period

Discharges January 1 through December 31

Denominator Sampling Frame

Patients associated with provider

Denominator (Index) Event or Characteristic

Clinical Condition

Institutionalization

Patient/Individual (Consumer) Characteristic

Denominator Time Window

not defined yet

Denominator Inclusions/Exclusions

Inclusions

Discharges with International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Principal Diagnosis Code for heart failure (HF) as defined in the appendices of the original measure documentation, and
A discharge to home, home care, or court/law enforcement

Exclusions

Patients who had a left ventricular assistive device (LVAD) or heart transplant procedure during hospital stay (ICD-9-CM procedure code for LVAD and heart transplant as defined in the appendices of the original measure documentation)
Patients less than 18 years of age
Patient who have a Length of Stay greater than 120 days
Patients with *Comfort Measures Only* (as defined in the Data Elements) documented
Patients enrolled in a *Clinical Trial* (as defined in the Data Elements)
Patients discharged to locations other than home, home care, or law enforcement
Patients with a documented *Reason for No Post-Discharge Appointment Within 7 Days* (as defined in the Data Elements)
Patients who left against medical advice (AMA)

Exclusions/Exceptions

not defined yet

Numerator Inclusions/Exclusions

Inclusions
Patients for whom a follow-up appointment for an office or home health visit for management of heart failure was scheduled within 7 days post-discharge and documented including location, date, and time

Exclusions
None

Numerator Search Strategy

Institutionalization

Data Source

Administrative clinical data

Paper medical record

Type of Health State

Does not apply to this measure

Instruments Used and/or Associated with the Measure

- Advanced Certification Heart Failure (ACHF) Initial Patient Population Algorithm Flowchart
- ACHF-02: Post-Discharge Appointment for Heart Failure Patients Flowchart

Computation of the Measure

Measure Specifies Disaggregation

Does not apply to this measure

Scoring

Rate/Proportion

Interpretation of Score

Desired value is a higher score

Allowance for Patient or Population Factors

not defined yet

Standard of Comparison

not defined yet

Identifying Information

Original Title

ACHF-02: post-discharge appointment for heart failure patients.

Measure Collection Name

Advanced Certification in Disease-specific Care Measures

Measure Set Name

Heart Failure Standardized Performance Measures

Submitter

The Joint Commission - Health Care Accreditation Organization

Developer

The Joint Commission - Health Care Accreditation Organization

Funding Source(s)

Unspecified

Composition of the Group that Developed the Measure

Unspecified

Financial Disclosures/Other Potential Conflicts of Interest

Unspecified

Endorser

National Quality Forum - None

NQF Number

not defined yet

Date of Endorsement

2015 Jun 29

Core Quality Measures

Cardiology

Adaptation

This measure was not adapted from another source.

Date of Most Current Version in NQMC

2015 Mar

Measure Maintenance

Unspecified

Date of Next Anticipated Revision

2015 Jul

Measure Status

This is the current release of the measure.

The measure developer reaffirmed the currency of this measure in April 2016.

Measure Availability

Source available from The Joint Commission Web site .

For more information, contact The Joint Commission at One Renaissance Blvd., Oakbrook Terrace, IL 60181; Phone: 630-792-5800; Fax: 630-792-5005; Web site: www.jointcommission.org .

NQMC Status

This NQMC summary was completed by ECRI Institute on May 21, 2015. The information was verified by the measure developer on June 15, 2015.

The information was reaffirmed by the measure developer on April 6, 2016.

Copyright Statement

Production

Source(s)

The Joint Commission. Disease-specific care certification program. Advanced certification heart failure: performance measurement implementation guide. Oakbrook Terrace (IL): The Joint Commission; 2015 Mar. 76 p.

Disclaimer

NQMC Disclaimer

The National Quality Measures Clearinghouseâ„¢ (NQMC) does not develop, produce, approve, or endorse the measures represented on this site.

All measures summarized by NQMC and hosted on our site are produced under the auspices of medical specialty societies, relevant professional associations, public and private organizations, other government agencies, health care organizations or plans, individuals, and similar entities.

Measures represented on the NQMC Web site are submitted by measure developers, and are screened solely to determine that they meet the NQMC Inclusion Criteria.

NQMC, AHRQ, and its contractor ECRI Institute make no warranties concerning the content or its reliability and/or validity of the quality measures and related materials represented on this site. Moreover, the views and opinions of developers or authors of measures represented on this site do not necessarily state or reflect those of NQMC, AHRQ, or its contractor, ECRI Institute, and inclusion or hosting of measures in NQMC may not be used for advertising or commercial endorsement purposes.

Readers with questions regarding measure content are directed to contact the measure developer.